Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-08-1486-01

MFDR Date Received
October 31, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Impatient Per Diem: $2236.00 . . . Insurance Payment: $1740.00 . . . Additional payment order amount: $496.00 + all accrued interest $26.44"

Amount in Dispute: $496.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per PPO Contract – Straight Inpatient rate = 1056.00 per day – Carrier agrees to pay add'l $372.00 Please see attached provider contracted First Health 1/1/97. Rule 134.202(d)(3) applies."

Response Submitted by: The Hartford, 300 S. State Street, Syracuse, New York 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2006	Inpatient Hospital Services	$496.00	$152.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401 sets out the fee guideline for inpatient hospital services.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.

4. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMP ST FEE SCHED ADJUST. SUBMITTED SERVICES WERE REPRICED IN ACCORDANCE WITH STATE PER DIEM GUIDELINES.
   - W1 – WORKERS COMP ST FEE SCHED ADJ RX ADMINISTERD DURING ADM AND GREATER THAN $250 CHARGED PER DOSEE SHALL BE REIM. AT COST PLUS 10% ELSE INCLUDED IN THE PERDIEM RATE PER THE TX ACUTE CARE INPATIENT HOSP FEE GUIDELINE.
   - W1 – WC STATE FEE SCHED ADJUST. SUBMITTED SERVICES ARE CONSIDERED INCLUSIVE UNDER THE STATE PER DIEM GUIDELINES.
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. IF YOU HAVE ANY QUESTIONS PLEASE VISIT WWW.FIRSTHEALTH.COM OR CALL 800-937-6824.

Findings

1. The insurance carrier reduced payment for the disputed service with reason codes 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. IF YOU HAVE ANY QUESTIONS PLEASE VISIT WWW.FIRSTHEALTH.COM OR CALL 800-937-6824." Review of the submitted information found insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 11, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the network and the requestor, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 *Texas Register* 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." Review of the subsequent information submitted by the respondent finds insufficient documentation to support that the services in dispute are subject to a contractual fee arrangement between the parties to this dispute. No documentation was found to support that insurance carrier had been granted access to the health care provider's contractual fee arrangement with the alleged network. Furthermore, insufficient documentation was presented to support that the alleged network had a contractual fee arrangement with Renaissance Hospital. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The respondent's rationale for maintaining the reduction or denial, as stated on the respondent's Table of Disputed Services, asserts that "Rule 134.202(d)(3) applies." The Division notes that former 28 Texas Administrative Code §134.202 applies to professional services, not to the facility services of an inpatient hospital. Accordingly, the appropriate rule for reimbursement is former 28 Texas Administrative Code §134.401, the *Acute Care Inpatient Hospital Fee Guideline.*
3. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the length of stay was 2 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $2,236.00.
4. Additionally, review of the submitted records finds that the health care provider billed for pharmaceuticals exceeding $250.00 per dose. Per §134.401(c)(4)(C) "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%." However, review of the submitted documentation finds no documentation of the cost to the hospital of the disputed pharmaceuticals. Therefore, no additional reimbursement can be recommended.
5. The total recommended reimbursement for the services in this dispute is $2,236.00. This amount less the amount previously paid by the insurance carrier of $2,083.86 leaves an amount due to the requestor of $152.94. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that additional reimbursement is due. As a result, the amount ordered is $152.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $152.94 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 30, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.